Remarks for Jeff Flick's testimony at The Little Hoover Commission on 1/25/07

1. Describe for the Commission the goals of HHS/ CMS to transform health care, the resources deployed to meet those goals, and any partnerships that enable progress toward these goals.

President Bush's August 22 Executive Order has four cornerstones: transparent quality information; transparent price information; interoperable health IT, and incentives for high-quality, efficient health care delivery. These tenets have all been priorities of HHS and CMS for some time.

CMS is working with HHS to identify and encourage standards that lower barriers to IT adoption and interoperability. We've developed and implemented terminology and messaging standards for administrative functions and e-prescribing foundation standards for Part D for the Medicare Modernization Act. We're working with the Healthcare Information Technology Standards Panel which has recently approved new standards for sending and receiving lab results and for sharing clinical data across emergency departments to identify additional standards. CMS is also a major player in the American Health Information Community (AHIC), which is a federal advisory body, chartered in 2005 to make recommendations to the Secretary of HHS on how to accelerate the development and adoption of health information technology. AHIC was formed by the Secretary to help advance efforts to achieve President Bush's goal for most Americans to have access to secure electronic health records by 2014.
CMS has assisted in promoting the adoption of electronic health records. Through the Doctor's Office Quality - Information Technology (DOQ-IT) project CMS is working to support the adoption and effective use of information technology by physicians' office to improve quality and safety for Medicare beneficiaries and all Americans. DOQ-IT seeks to accomplish this by promoting greater availability of high quality affordable health information technology, by providing assistance to physician offices in adopting and using such technology. We've implemented e-prescribing pilots, tested the sending of Medicare data to personal health records, and demonstrated incentives to use IT in managing chronic care.

CMS is posting quality data on hospitals, nursing homes, home health agencies, and dialysis facilities on the Medicare.gov website, as well as quality data for Medicare Advantage plans.

We are developing a model for quality measurement for physicians through the Physician Voluntary Reporting Program (PVRP) and through ongoing work with the Ambulatory Care Quality Alliance (AQA), the American Medical Association's Consortium for Performance Improvement, and the National Committee for Quality Assurance (NCQA).

We are continuing to work with broad stakeholder coalitions to adopt additional quality measures. CMS has a central role in the National Quality Forum, and in addition to the AQA, we are participating in the Hospital Quality Alliance (HQA) and the Pharmacy Quality Alliance (PQA) to identify quality measures and ways to ensure their use.

CMS released Medicare payment information last June 2006 on services delivered in hospitals, and in August 2006, on ambulatory surgery centers. In November, we have

posted similar information on outpatient departments and physician services. The CMS website provides a sophisticated level of information on Medicare prescription drug plans, including details on premiums, cost-sharing features, formularies, and expected out-of-pocket costs. In collaboration with the AQA, we are evaluating strategies to measure the resources used to deliver broader episodes of care.

CMS is currently implementing the Better Quality Information (BQI) for Medicare Beneficiaries Project in six communities across the country. In these communities, employers, health insurance plans, and in some cases Medicaid programs and providers, have formed collaborative groups which combine claims data or clinical information to provide consistent measures of health care quality.

One of the pilot sites is here in California. The California Cooperative Healthcare Reporting Initiative (CCHRI) is a collaborative of health care purchasers, plans and providers. The Pacific Business Group on Health manages CCHRI to promote collaboration in building and maintaining health plan and provider performance information.

Through the BQI project, CMS will allow the private data to be aggregated with Medicare claims data to produce more accurate, comprehensive measures of the quality of services at the provider level. The work of these regional communities will provide a broad overview of provider performance. CMS and HHS are considering ways to expand this project to additional communities.

We are building pay-for-performance strategies into Medicare payment for physicians, hospitals, and home health agencies. We are testing pay-for-performance strategies in the real world, through such models as the Premier Hospital demonstration, the Physician Group Practice Demonstration, and the Medicare Health Support Pilot.

Following the lead of the private sector, we will offer Medicare Savings Accounts (MSA) to Medicare beneficiaries for the first time in 2007. Because each MSA has to provide information on quality and price as a condition of contracting with the Medicare program, they will help promote beneficiary use of quality and price information.

Another big push is the vision of creating an environment where a consumer, caregiver, or counselor can access a website and with just one click, find information on the cost and success rates of community providers:

- For elective procedures (how many are performed, outcome information such as success or complication rate, and how much they charge);
- For people with chronic illnesses, similar performance information will be available over the course of the illness.
- Simply to find a provider who treats their particular condition in their area.

In order for this vision to succeed it will have to be a public-private partnership, which includes a wide array of stakeholders, including hospitals, physicians, employers, unions, insurance plans, state and local governments, and the consumers who will be the end-users.

At CMS we've moved a little closer to this vision with a new campaign called My Health, My Medicare. The campaign is aimed at helping every person with Medicare coverage get the most out of their benefits. It is an important step toward personalized health care that focuses on the individual rather than the service they are receiving. My Health, My Medicare is making it possible for people to evaluate their coverage and make maximum use of preventive and other important Medicare benefits through the internet.

MyMedicare.gov provides easy access online to personalized information about all benefits and claims, available prescription drug plan choices and enrollment options, provider quality measurements and a variety of other personalized health management tools; including a full array of tools to help choose health plan coverage, not just drug coverage. The new options web-tool allows consumers to receive personalized information on the total estimated out of pocket cost for each Medicare option available to them in their zip code. This same information is also available to beneficiaries who prefer to access information via the phone at 1-800-Medicare.

The Part D Plan Finder provides an unprecedented level of information on price of plans and expected out-of-pocket costs for prescription drug plans. We've made the Plan Finder even more user-friendly for the prescription drug benefit's 2007 enrollment period. It has personalized information on the availability of generic drugs and other lower-cost therapeutic substitutes under Part D, as well as a program showing how much beneficiaries can expect to spend on a monthly basis over the course of the year. In addition, the website now features a series of performance metrics on how plans performed in 2006 in a number of key areas. We know our beneficiaries, their families, and their caregivers are appreciative of this information.

This year, there have been almost 34 million hits to the Hospital Compare site alone through mid-September. There have been over 237 million hits to the Plan Finder tool over the last year. Medicare beneficiaries are proving to be smart shoppers. They know that they can get the same quality with generic drugs at a much lower cost. The majority of Part D enrollees are in plans that offer more than 1,000 generic medications on their formularies. Most beneficiaries chose plans with non-standard benefit design: In 2006, 81 percent of PDP enrollees and 95 percent of MA-PD enrollees were in drug plans that provided a benefit structure different from that of the standard benefit designed by Congress ($250 deductible, no gap coverage). There have been more than 930,000 new Part D enrollees since May 15th 2006; 316,000 of those enrolled online between November 15th and December 31st, 2006. Early evidence reveals that beneficiaries enrolled in Part D are relying on generics to a greater extent than the U.S. population as a whole. Nationwide, among all payers, the proportion of generic usage stands at 56 percent. Recent CMS data show that generic usage among all types of Part D plans was 60 percent during the first two quarters of 2006. This is at least part of the reason why the actual cost of the new prescription drug benefit is nearly 40% lower than the original estimates of the costs of this new benefit.

Overall satisfaction with Part D continues to be extremely high among enrollees in the Medicare drug benefit. Despite some early concerns about the array of plan choices being overwhelming for seniors, 88 percent say they did not experience any problems signing up for the new benefit, according to a survey conducted for America's Health Insurance Plans (AHIP)—and 69 percent of seniors saying that the time and effort they put into evaluating their choices was worth it.

CMS is now reporting on new quality metrics for customer service under Part D. Consumers are able to see how plans are rated in the following areas of customer service: telephone customer service, complaints, appeals, and sharing information with pharmacists. These tools will enhance Medicare beneficiaries' ability to compare plans and select the plan that works best for them.

In working with our states, CMS is responsible for supporting State Medicaid and SCHIP programs in their efforts to achieve safe, effective, efficient, patient-centered, timely and equitable care. CMS will partner with States to share best practices, provide technical assistance to improve performance measurement, evaluate current improvement efforts to inform future activities, collaborate with quality partners and coordinate Center activities to ensure efficiency of operations. For example, California has implemented a *Performance Based Auto-Assignment Program* that rewards health plans with superior performance. The program creates an incentive to improve Medicaid quality and preserve the safety net by increasing enrollee volume and payment to those plans that provide a consistent level of quality improvement.

CMS recently developed a Medicaid/SCHIP Quality Strategy. Key strategies include: (1) Evidenced-Based Care and Quality Measurement (2) Payment Aligned with Quality (3) Health Information Technology (4) Partnerships (5) Information Dissemination, Technical Assistance, and sharing of best practices.

On February 8, 2006 the President signed the Deficit Reduction Act of 2005 (DRA). This sweeping legislation affects many aspects of domestic entitlement programs, including both Medicare and Medicaid.

The DRA provides states with much of the flexibility states have been seeking over the years to make significant reforms to their Medicaid programs. Combined with other options in Medicaid, states will be able to reconnect their healthy populations to the larger health insurance system, transform long-term care from an institutionally-based, provide-driven system to a person-centered and consumer-controlled model. There are great opportunities for covering more people at a lower cost, and with greater continuity of coverage.

2. Share what you believe the State's goals should be for health care in California.

I believe the State of CA strongly supports the four cornerstones of the Value Driven Health Care Initiative: transparent quality information; transparent price information; interoperable health IT, and incentives for high-quality, efficient health care delivery.

Challenges:

3. Comment on the barriers that impede access to affordable, high-quality health care and obstacles that prevent data-based decision making and the implementation of health information technology.

The biggest barrier to having high quality and affordable health care has been the lack of the four cornerstones outlined in the Presidential Executive Order on Value Driven

Health Care. Almost every market within the United States is rich with information on product or service performance. If the consumer is interested in buying an automobile, refrigerator, a good hotel, or for that matter a good pizza pie, there is a wealth of information available on quality, safety, performance and price. This is true in virtually every sector of our economy except health care. The value driven health care initiative will transform that reality and it will also provide an inter-operative health care IT environment and the use of incentives to enhance health care performance.

The movement for high-quality, low-cost, transparent health care is advancing in both public and private sectors. There is a need to harmonize our efforts. In order to be successful, a common evidence base with which to measure quality must be established. We need to have our information systems using the same terminology and speaking the same interoperable language. We all have to work from the same set of quality and efficiency parameters.

CMS believes that consumers including Medicare beneficiaries are very capable of making good health care decisions if they have access to the information on both on the quality and cost of that care. In private plans, on Web-MD, millions of people used web-based tools in 2006 fall's open enrollment period to evaluate plans and make their choices. This consumer-powered trend is gaining momentum.

We know that there will be challenges as we push ahead with the four cornerstones, but we can't lose sight of the unique opportunity we have, together, to transform the health care system. It will take commitment and leadership at all levels of the federal, state, county, and private sectors. This is the same vision as Mark McClellan had, and Tom Scully had before him. It's the vision laid out in the President's August 22 Executive Order. CMS can make a difference, but we can't do it alone. This effort requires broad based support from both the public and private sectors.

Strategies:

4. Discuss the strategies employed by CMS to promote the development of standards for data-based decision making and health information technology, accountability, performance management and interoperability.

CMS is working with HHS to secure commitments from a broad range of stakeholders including governmental entities, private sector, labor unions, health plans, providers, and others to support the four cornerstone objectives. The federal government has already acted as demonstrated by the President's August 22, 2006 Executive Order. I am pleased to report that in addition to the Executive Order, we have firm commitments from 110 major employers throughout the United States of America including several large organizations in CA. Our goal is to secure commitments from health care payers, including government and private sectors that cover 60% of the consumers in the United States by the summer of 2007. If we obtain the commitment of 60% of the health care payers in the United States, we believe that we will have achieved a tipping point that will have truly transformed health care in the US. We affirm that it is possible to fundamentally improve the care for all Americans while achieving enhanced efficiency and better use of health care resources.

Thank you for the opportunity to be here today.